OPP Exam:

Board Review: _____
Cert No.: _____
Date Issued: _____

OFFICE USE ONLY

Date Rec'd: _____
Am't Rec'd: _____

State of Maine
BOARD OF OSTEOPATHIC LICENSURE
State House Station #142
Augusta, Maine 04333
Tel: (207) 287-2480

APPLICATION TO PRACTICE OSTEOPATHIC MEDICINE ON THE BASIS OF

National Boards____ FLEX____ USMLE____ State Exam (Name State)_____

Date of Application_____

1. I hereby apply for licensure to practice osteopathic medicine in the State of Maine and submit the following information:

Name_____ Male ____
Last First M.I. Female ____

Address_____ Birthplace:_____
_____ Birthdate:_____
City State Zip Mo. Day Year

Telephone:_____ SS#_____
(Home) (Business)

Proposed Practice Site_____

2. AFFIDAVIT

I hereby certify that the information given in this application is true and accurate and that the attached is a true photograph of me. I understand that any false answer may result in denial , suspension, or revocation of my license to practice osteopathic medicine in Maine.

Applicant must sign full name in the presence of a notary public who must complete the affidavit and affix notarial seal over a portion of the photograph.

Signed:_____
(Signature of the Applicant)
Subscribed and sworn before me on the _____day of _____ 20_____.
Signed:_____
(Signature of Notary Public)
Notary Public for the State of _____

Attach Recent Passport Photograph in this Space

Notary Seal
Must cover portion of photograph

3. Osteopathic Education

It is hereby certified that I, _____D.O., possessing the preliminary education received from the _____ a diploma conferring upon me the degree of DOCTOR OF OSTEOPATHY; that said diploma was received on the _____ day of _____ 19/20_____.

Specialty _____ A.O.A. Board Certified: Yes____ No:____ Board:_____

Other Certifications: _____
_____

4. Licensure in other states (including any jurisdiction where you are no longer licensed):

State	**Year Licensed**	**Status (lapsed, inactive, active)**	**Year of Status Change**

5. Professional Experience:

List in chronological order all professional education and experience (include college, medical school, post graduate training, and practice. Please include all periods of time from graduation of osteopathic medical school to present whether or not you were engaged in medical activities. Include month, year, and FULL addresses with zip codes. Attach additional sheets of paper if necessary.

From Mo. Yr.	To Mo. Yr.	Name of Hospital or Institution	Address	Nature of Experience

6. Personal Data:

Please answer all questions. If any of the following questions are answered "yes", full details must be furnished on a separate sheet and attached to the application. (To the extent allowed by law, all answers will be kept confidential.)

In the past five (5) years, have you:

1. Had a disabling physical or mental illness(es) that resulted in any hospitalization or that prevented you from working or carrying out your usual daily responsibilities for more than thirty (30) days? Yes___No___
2. Been told by a professional or peer that you have an ongoing medical (including substance abuse), surgical or psychiatric condition that has or could impair you practice of medicine, or been advised to seek treatment for any of these conditions? Yes___No___
3. Been addicted to or abused any substance or drug (including the use of alcohol)? Yes___No___

Now or at any time in the past, have you:

4. Been arrested or convicted for anything other than minor traffic violations (OUI is not considered a minor traffic violation)? Yes___No___
5. Had findings of sexual misconduct made against you (including sexual harassment)? Yes___No___
6. Been notified of an investigation or complaint or had any disciplinary action or sanction (including find) taken against you (voluntary or otherwise) by the licensing board of this state or any other jurisdiction? Yes___No___
7. Had your staff privileges at any hospital, nursing home, or other health care provider terminated, reduced, revoked, restricted, suspended, or been put on probation by any of these facilities or providers? Yes___No___
8. Been notified of an investigation or complaint or been sanctioned in any way by a professional society? Yes___No___
9. Been notified of an investigation or complaint or had any sanction, recoupment or other adverse action taken of any kind against you by a third party reimbursement program, whether private or government financed (such as Medicare or Medicaid)? Yes___No___
10. In anticipation of or during the pendency of any investigation or other disciplinary proceeding (whether by a state board, hospital, health care provider, or peer review) voluntarily surrendered any professional license, certificate, registration, or privileges issued to you? Yes___No___
11. Had malpractice award(s), judgment(s), or settlement(s) against you? Yes___No___
12. Been involved in any medical malpractice claim or lawsuit, or been notified by an insurance company that a claim may be filed against you? Yes___No___
13. Lost your medical malpractice insurance coverage or had an application denied for any reason? Yes___No___
14. Been notified of an investigation or complaint or had any adverse action or sanction (e.g., suspension, restrictions, revocation) taken against you whether voluntary or otherwise by the DEA? Yes___No___
    (Please list, if any, your current DEA license number and the state where the license was issued: #_____; State_____.)
15. Discontinued practice for any reasons for a period of one month or more? Yes___No___
16. Applied for licensure or to sit for an examination, or taken an examination, under a different name? Yes___No___

PLEASE PROVIDE SPECIFIC DETAILS TO ANY AFFIRMATIVE ANSWERS

ALL QUESTIONS MUST BE ANSWERED AND THE FEE MUST BE INCLUDED OT THE APPLICATION WILL NOT BE PROCESSED!

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional business associates (past and present), medical malpractice carrier and all government agencies and instrumentalitites (state and federal) to release to this licensing board any information, files, or records required by the board for its evaluation of any professional and ethical qualifications or licensure in the State of Maine.

Dated:_____ _____

Signature of Applicant

_____

Type or Print Name

Certificate of Medical Education

Maine Board of Osteopathic Licensure

This section to be completed by Applicant

Applicant:
Please complete the top portion of this form, attach a passport sized photo below and submit to your medical school. They will complete the form and return it directly to this office.

Your Name _____

Your Mailing Address _____

_____

Daytime Contact Phone: _____

This section to be completed by Dean's office

Medical School Dean:

- **Please complete the bottom portion of this form and affix the medical school seal on the photo below.**
- **Please return it directly to this office with an original transcript of the physician's courses and grades in a sealed envelope.**
- **Medical school seal or medical school official signature must be affixed across the seal of the envelope.**

I hereby certify that the Degree Doctor of _____ was conferred

upon _____, by the _____

Name of Applicant **Name of Medical School**

on _____ and that the photograph which appears below is a true likeness

of the physician named above.

Applicant:

Please affix a recent passport sized photo to this box before forwarding to your medical school

Thank You

Signature of School Official:_____

Printed Name of Official:_____

Name of Medical School:_____

Please Affix Official School Seal Here

Current Name of Medical School (if different from date of graduation)

_____

Maine Board of Osteopathic Licensure
142 State House Station, Two Bangor Street, Augusta, ME 04333-0142
Telephone: 207/287-2480

Verification of State Licensure Form

APPLICANT: Please complete top section of form and mail to the Board of any state in which you are now or have ever been licensed to practice (temporary or permanent) osteopathic medicine. Duplicated forms are acceptable.

BOARD SECRETARY: I am applying for a license with the Maine Board of Osteopathic Licensure. The Board requires that your Board complete this form in order that I may be considered for licensure.

_____ _____
Print or Type Full Name Applicant Signature

_____ _____
Mailing Address License # and Issue Date

_____
City State Zip Code

The section below MUST be completed by an official of the Board and returned to this address:

Maine Board of Osteopathic Licensure
142 State House Station, Two Bangor Street
Augusta, ME 04333-0142

This is to certify that the records of the _____ Board in the State of _____ indicate that _____, D.O. was issued license number _____, dated _____ to practice osteopathic medicine on the basis of:

State Exam: _____ Flex Exam: _____ Reciprocity: ____ National Boards: _____

1. License is current and in good standing? Yes___No___
2. Has the holder of the license ever been summoned to appear before the Board? Yes___No___
3. Has the holder of the license ever been placed on probation? Yes___No___
4. Has his/her license ever been suspended or revoked? Yes___No___

If you answered yes to 2, 3 or 4 above or are aware of any derogatory information, please provide full details and copies of applicable documents.

Dated: _____

Signed:_____ Board Seal

Title: _____

Name of Board: _____